THE BILL BLACKWOOD
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The Carotid Neck Restraint; Does it Belong in the Use of Force Continuum?

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Abstract

Today's law enforcement organizations are under scrutiny by both society and courts, over any use of force against the public. The cause for the use of force seems irrelevant and the resistance faced unimportant. The fact is that if an officer uses a defensive maneuver, which is approved by the department, and uses it inappropriately or misapplies the technique, the technique could possibly be stricken from the use of force policy of the whole department. The carotid neck restraint [CNR], also known as the lateral vascular neck restraint [LVNR], has been under such scrutiny for numerous years and many departments have decided that its value does not outweigh its liability.

The purpose of this paper is to research the areas of concern relating to deaths that have been attributed to the use of the CNR. This paper will also review the CNR's history and the development from a commonly used judo technique, "shime-waza", to a law enforcement officer's tool to combat violence. The CNR in the use of force continuum at the deadly force level is addressed. Legal issues relating to the use of the hold and the litigation that follows are examined. A look into the sudden death syndrome, misapplication due to lack of training, and other possible causes of deaths in which the CNR received the majority of the blame are presented. Outside studies are reviewed to compare results of other agencies to help determine the feasibility of the CNR in a law enforcement environment.

The conclusion of this research indicates that the CNR has been discredited by the failure to obtain thorough death investigations. Due to the lack of other evidence, autopsies often concluded the CNR to blame in many deaths. The CNR has been further tainted by the misapplication of improperly or under trained officers. Training must be the focus when allowing the use of the CNR. This research shows the CNR/LVNR is a safe and effective maneuver when used by a properly trained officer. It is a vital tool when an officer is outmatched or outweighed by the combatant involved. Further, it is important that the CNR be placed in the use of force continuum at a level that it is accessible when needed. The CNR is useless if it is not available to the officer before deadly force is appropriate.

Introduction

The carotid neck restraint [CNR], also known as the lateral vascular neck restraint, has been used by many law enforcement agencies nationwide. This research will answer two questions regarding the restraint. First, should law enforcement personnel use this form of weaponless restraint and include it in their use of force continuum? Second, if it is used, where should it be placed within the use of force continuum?

The issue of the CNR is whether it is safe to use. Have past incidents involving the death of individuals being arrested caused law enforcement to ban its use altogether, or have these incidents caused .departments to move it higher on the use of force continuum causing it to become inaccessible to officers? The classification of the CNR at the "deadly force" level in a continuum causes questions to arise. When the CNR has caused death, was it applied incorrectly? Should we hold the type of restraint used responsible? Or, should we scrutinize the training, or the lack thereof, of the officer applying the restraint? This report shall answer these questions for policy-makers, administrators, trainers and officers from a diversity of departments.

Surveys of other departments' policies, articles from law enforcement and medical journals, books, current training guidelines and use of force continuums from a variety of law enforcement departments will be used for information pertaining to the use of the CNR and its practicality in the law enforcement environment.

This article will shed light on problems with the use of the CNR and allow each department to determine the feasibility of its use. Also, if the CNR is implemented or allowed to continue, this report shall give insight as to what level it should be placed at in the use of force continuum and show that training is a department's best prevention against misapplication.

Historical, Legal and Theoretical Context

The carotid neck restraint [CNR] used in law enforcement is a derivative of the "shime-waza"; a chokehold or "sleeper hold" used in Judo since 1882. There are many methods of application in Judo. The Judo uniform, a gi, is commonly used to compress the carotid arteries which restricts blood flow to the brain and obtains the physiological effect of the hold. Law enforcement adopted the hold in the mid 1970's and modified it to fit the needs of the law enforcement officer. The use of neck restraints has become more and more controversial as law enforcement faces continued scrutiny in the use of any type of force.

The magnification of problems with neck restraints came in 1975 to 1982 when the Los Angeles Police Department [LAPD] had fifteen [15] deaths related to the application of neck restraints. The chokehold was used 138 times during this period while making 52,162 arrest during the same time span (Fyfe, 1983). These deaths caused a national spotlight on the use of neck restraints by law enforcement officers. This illumination caused the reporting of other deaths across the nation that were said to be caused by or related to the use of neck restraints. Though the arm bar chokehold was also being used by the LAPD, the carotid neck restraint was not specified as the type of neck restraint used in the majority of these cases. All neck restraints were scrutinized under the same umbrella though there are major differences between them.

The litigation due to the use of neck restraints grew at a rapid rate when the national media began to examine this use of force. The lawsuits brought forward facts that are helpful in determining what neck restraint was used or attempted. Also, the cases show the physiological effect of the two types of neck restraints, respiratory and vascular. Respiratory choke holds cut off the air flow while vascular neck restraints do not cut off air flow but restrict blood flow to the brain and face. All of the

cases reveal the importance of officer discretion in a use of force situation. .

The courts have made it clear that they will accept these cases on the constitutionality of neck restraints as a type of use of force. "The strangle holds challenged here may be illegal or they may not be. But as long as we refuse to allow anyone to attack their constitutionality here, we tell the citizen that there is no guardian of his constitutional rights" *(City of Los Angeles* v. *Lyons*, 461 U.S. 95 (1983), 615 F.2d 1243 (9th Cir. 1980)). Court decisions have a direct influence in the discretionary use of force by police in setting the standards of force *(Graham* v. *Connor*, 109 S.Ct. 1865 (1989)), standard of training in the use of force *(Popow* v. *City of Margate*, 476 F.Supp. 1237, 1246 (N.I 1979)), and the role of written policies affecting police liabilities *(Delong* v. *the City and County of Denver*, 530 P.2d. 1308 (Colo. App. 1947), Affirmed 545 P.2d 154 (1976)).

One of the initial issues looked at by the courts anytime a peace officer uses force is the training of the officer involved. The court has ruled that a new officer must have adequate training in all areas of the use of force that are approved in each department. In some cases, especially in use of force that can cause serious bodily injury or death, post-recruit training may be necessary as a continued means of supplying knowledge of proper use and application of certain defensive measures *(McQuarter* v. *City of Atlanta*, 572 F.Supp. 1401 (N.D. Ga. 1983)). Courts have shown support for the use of the carotid neck restraint when used in a one on one scenario and the suspect is clearly resisting the officer *(Gassner* v. *City of Garland. Texas*, 864 F.2d 394 (5th Cir. 1989)). But the use of neck holds have been viewed negatively by the courts when used in situations involving a single suspect and numerous officers *(Hay* v. *City of Irving. Texas*, 893 F.2d 796 (5th Cir. 1990); *Simpson* v. *Hines*, 903 F.2d 400 (5th Cir. 1990)), after a suspect has already been restrained or handcuffed *(McQuarter* v. *City of Atlanta*, 572 F.Supp. 1401 (N.D. Ga. 1983)), and when the carotid neck restraint is used as a continual

use of force, as in numerous applications *(Raley* v. *Fraser,* 747 F.2d 287 (5th Cir. 198)).

It has been theorized that the nature of the carotid neck restraint's [CNR], physiological effects of cutting "all" blood flow to the brain, is lethal in itself If this theory were correct it would likely be true. However, the theory has been studied and proven to not be the correct assumption of the effect of the hold. "The vertebral arteries are capable, should the carotid arteries be compressed, of taking over the blood supply to the head. Therefore, contrary to conventional teachings in the fighting arts, the blood supply to the head cannot be completely stopped by compression of the carotid arteries nor, for similar reasons, can the deoxygenated blood collected by the jugular veins be totally stopped (Hibbard, 1980).

Review of Literature or Practice

The physiological effects of the CNR have been studied by many to see if the restraint, if used properly, was as lethal as the reputation has insinuated. Soon After the Los Angeles Police Department's ban of neck restraints, the Federal Bureau of Investigation [FBI] conducted its own research into the physiological effects of the CNR. This research was closely supervised under controlled conditions to insure the safety of the participants. This research also brought the FBI new knowledge on the effects of the CNR:

> It was concluded that the carotid blood flow is severely restricted to the head during proper application of the carotid sleeper. Blood flow to the face was reduced to an average of 89.4 percent and the reduction started as soon as the neck compressions started. Because of the organs involved, neck holds must be considered potentially lethal whenever applied. (Reay, 1983)

This opinion tends to differentiate from the results of the International Association of Chiefs of

Police [IACP]. The IACP looked into the carotid neck restraint [CNR] in a comparative analysis to other means of force by police officers. The summary of their research concluded:

> The truth is that the neck restraint is the only method that can be applied to a violent subject that will not cause injury the majority of the time it is used. It is probably the single most humane method of controlling a violent subject. In some of these deaths [attributed to chokeholds**],** injuries to the trachea area have occurred causing death. These cases are rare. Literally tens of thousands of violent, combative subjects have been subdued by the neck restraint with only a few, probably less than one percent, suffering serious injury or death. Compare this figure with the number of deaths that can occur with the use of the baton, taser, firearm, tear gas, and other forms of restraint. (IACP, 1990: 59)

These two studies show the vast differences in opinion that exist when discussing CNR and they explain the vast differences in the usage and non-usage of the CNR in law enforcement entities around the United States. As reported by Arthur G. Sharp, a poll conducted among law enforcement agencies of varying sizes across the U.S. revealed that only 30 percent of them use the CNR, even though it is taught in 37 percent of their police academies. By comparison, 30 percent have a ban on its use. More importantly, 64 percent of those departments that do use neck holds would discontinue them if they received ample proof that they are lethal. Ironically, 58 percent of the respondents considered the CNR an effective technique; only 18 percent feel it is not with the remaining 24 percent unsure (Sharp 1989).

James Lindell, of the Kansas City, Missouri Police Department [KCPD], looked into the functions of the human body when a choke hold was applied. Through this research, Lindell was able to make modifications to the carotid neck restraint to produce a safer and more effective hold. Lindell's hold is known as the Lateral Vascular Neck Restraint [LVNR]. "It is a subtle variation on the

carotid [hold] which makes it mechanically more difficult for the officer to slip into the more dangerous arm-bar" (Rohrlich 1991: A28). "As of today, only the Lindell Neck Restraint System has the track record of no deaths or injuries since its development in 1970. This record indicates that there is a safe alternative to the obvious problems of other-neck restraint systems"(PPCT, 1993: 7-1). "The LVNR is safely used about 20 times a day at the KCPD according to Lindell" (Rohrlich 1991: A28). The development of the LVNR and the record of safe usage of the hold have caused some major departments to reconsider the use of neck restraints. "LAPD department officials decided to reevaluate their earlier decision to prohibit neck restraints, in the belief that officers need to have a variety of the options to select from when confronted with resistant subjects and that, properly applied, neck restraints are extremely unlikely to produce serious injury" (Geller, 1992). Though some entities, such as LAPD, are reevaluating possible reinstatement of neck restraints, there are other large departments discontinuing the use of all neck restraints in the same time frame. Austin, Texas Police Department's [APD] use of force continuum included the CNR as of July 1992 (Austin PD, 1992). However, the CNR had been removed from the use of force continuum in a revision of the policy in November 1996 (Austin PD: 1996). This shows a contrast of opinion when it comes to the use of neck restraints even though improvements have been made due to the safety concerns of the hold.

Discussion of Relevant Issues

There are elements that pertain to the CNR that are relevant to the outcome of its use and the judgement that will be passed upon it.

Sudden Death Syndrome

Sudden death syndrome has been ruled the cause in numerous deaths when the reason for the person's demise was not clear.

> Current theory holds that some reflex mechanisms causing death are started by a state of mind. The belief is that extreme levels of agitation, or fear combined with hopelessness, produce an adrenal hormone [either epinephrine or catecholimine] that is secreted into the circulatory system. The heart is very sensitive to these hormones, which can trigger an irregular heart rate or ventricular fibrillation, a fatal arrhythmia. This type of reflex death does not leave changes in any organ and thus results in a negative autopsy. (McLaughlin, 1988)

If the CNR is used in a combative situation and the subject ultimately dies, the CNR seems to always be listed as a contributor to the cause of death even though the autopsy may be inconclusive, which further taints the reputation of the hold. Thus, "it is important that the medical examiner should examine the body and determine the cause of death before reading the reports of the incident so he will not fit the physical evidence mentioned to buttress the narrative" (Dimsdale, 1977). We all are aware that the coroners are pressured to give an answer without ambiguity to the cause of every death they investigate even when the answer may be unobtainable. "There is a lack of knowledge of how to assess deaths where the circumstances strongly indicate a traumatic cause of death, while the autopsy reveals no evidence of a life-threatening physical trauma" (McLaughlin, 1988). A question arises in our minds to the validity of autopsies in cases where the findings were inconclusive and then the fact came forward that a neck restraint was used. Was the CNR used as a scapegoat because of the lack of other explanations? There is no concrete evidence documented at this time; however, there will be no surprises to find that the sudden death syndrome was the cause in numerous cases where the carotid neck restraint [CNR] caught most the blame.

The CNR may have taken blame for deaths that it did not cause. The more we find out about sudden death syndrome, the more we see how this could happen. "Findings suggest that the cause of sudden death may lie to some degree in emotional fears, which either slowly creates in one's heart a

predisposition for death, or, in crises, abruptly causes it" (Monagan, 1986).

Training and Application

Lack of training in the usage of the CNR has to be considered a contributor to the problems that have arisen. Because a neck restraint is a dangerous use of force, we must give the training of officers the adequate time and attention this type of restraint mandates. This is usually not the case with most departments. "Most police officers receive only one lecture and, at the most, two demonstrations of the choke hold during the course of their academy training. This minimal training is totally, inadequate to assure they use the choke hold technique correctly, and that the officers understand the mechanics of the technique" (Creighton, 1983). Knowing the effects of the CNR and the vulnerability of the neck region are imperative for any officer allowed to use the CNR It would be unthinkable to allow an officer to continue to use a firearm while having only his initial academy training. The CNR is not as deadly but due to the atmosphere of public opinion and the propensity for untrained officers to make application errors, additional training should be required throughout the officer's career. We must ask ourselves how much more an officer will use the CNR than his firearm during his career? The answer is obviously numerous times more. Therefore Reay says it best, "Police officers should have continual in-service training and practice in the use of the carotid sleeper" (Reay, 1983).

"The officer who is well trained in defensive tactics is better able to ensure a successful and safe restraint without employing unnecessary force or risk of injury to the subject" (Braden, 1982). Dr. Koiwai gives an outline of training steps to follow to assure all aspects of the CNR are covered with training officers initially and during retraining.

The number of fatalities resulting from the use of chokeholds will

decrease if the following procedures are followed:

I. Chokeholds to be taught by trained and certified instructors:

A. to be familiar with the anatomical structures of the neck and where the pressure is to be applied (carotid triangle);

B. to know the physiology of choking, that only a small amount of pressure is needed to cause unconsciousness;

C. to recognize immediately the state of unconsciousness and to release the pressure immediately;

D. to learn proper resuscitation methods if unconsciousness is prolonged; and

E. to prevent aspiration of vomitus and not to place the restrained suspect face down. Keep the subject under constant observation" (Koiwai, 1987).

If these training steps are followed, it will benefit officers in knowledge and the application of the CNR. Trostle agrees, ". . .it must always be remembered that the tools we provide are only as good as the people to whom we entrust them" (Trostle, 1990). The people are only as good as the training provided

Allowing officers to use the CNR without proper and continual training can be very costly to the agency involved. Legal liabilities come to the forefront with any law enforcement use of force. Buckley concludes, ". . .training cannot inoculate a department from tort action; yet, training programs which are justified and documented can help to reduce or eliminate areas where police departments may be the most vulnerable to liabilities" (Buckley, 1996). It is well known that the "bar arm" choke hold is a lethal hold and should only be used in a deadly force situation. This fact about the bar arm chokehold has however, caused problems for advocates of the CNR. "History proves that people have died from a bar arm choke hold that looks a lot like a carotid neck restraint - and judges and juries paint with a broad brush. Now there is a legal precedent that naively lumps a safe control technique

with one that has caused death" (Clede, 1987). Due to their lack of knowledge on this issue, the courts have made departments apprehensive about employing any type of neck restraint. Intensive and documented training can overcome this precedent and give the courts a clear picture of the difference between the two types of neck restraints.

Effectiveness

The effectiveness of the CNR cannot be overlooked when weighing key issues of its use. " . . .the subject as well as the officer become a beneficiary of a properly applied neck restraint" (Braden, 1982). The most important aspect of any defensive maneuver is whether or not it has the desired outcome from its usage. "The more violent an attacker is and the bigger and stronger he is than you, the more valuable this control option (CNR) becomes. In trying to subdue actively resistant subjects whose rage, pain tolerance and strength are extraordinarily high, it may be the only unarmed technique that works" (Remsberg, 1986).

The CNR has a track record of being very effective in volatile situations. Now with the LVNR improvements, adjustments allow for escalation and de-escalation within the hold itself. The CNR/LVNR will continue to be a viable option used by law enforcement officers as long as there is a need for them to use force in protecting themselves or others. "It may be controversial, but it is effective, and that is the most important thing as far as officers are concerned" (Sharp, 1989).

Due to the effectiveness of this hold and the lack of serious injury documented by use of the LVNR exclusively, the CNR/LVNR must be put at a level in the use of force continuum that allows officers to use it without requiring illogical prerequisites to its application. There are numerous injuries that can happen in the use of other weapons such as batons, tasers and firearms. This fact would indicate that the CNR should be a lower form of force and be lower in the use of force continuum.

Remsbergs places the CNR appropriately in his use of force continuum ill knowing the results of the CNR are effective and not as dangerous as once presumed (Remsberg, Appendix A). However, no matter what the use of force enacted, if an officer is negligent or misuses any type of force, the officer should suffer any disciplinary action that may result. The rest of the department should not be punished by denying the use of any technique or tool with proven effectiveness.

Cost vs. Benefit

The amount of instructors needed and the amount of training involved in a department's program can only measure the cost of implementing a training. program for the usage of the CNR/LVNR. Demographics. become a factor at this stage as traveling may be required to obtain the instructional certification that is desired. Once trained, these instructors could economically train the rest of a department locally at the department's convenience.

Benefits include supplying the department with an effective defensive maneuver, which not only can save officers lives but also reduce the amount of injury to the subjects being subdued. The proper training for the CNR/LVNR has numerous advantages monetarily, and can greatly help in the arena of public opinion.

Conclusion and Recommendations

The purpose of this project was to research the use of the CNR by law enforcement agencies to determine if the CNR is a reasonable alternative in the use of force. The reputation of the CNR has grown worse over the years and many departments have banned its use or moved it higher in their use of force continuum making it useless to the officer. The issue examined is the history of the CNR, the validity of this restraint, and if its reputation may have been tainted by a lack of knowledge and false

information. The misapplication of the hold by poorly trained officers .has also contributed to the negative opinion attributed this restraint.

This research shows great possibility that the CNR has been used as a scapegoat in certain cases and was often confused with the lethal arm bar chokehold. Distinctive differences were not made between a respiratory chokehold and a vascular neck restraint in many departments. Of course, if we make no contrasts, the courts will follow suit as they have lumped the two together in determining outcome of litigation. This lack of distinction is erroneous from the start as the CNR with the LVNR modifications has proven to be an effective, safe and vital alternative for the well-trained officer. Officers who are over matched in size and strength have found the L VNR to be beneficial to them **and** the suspect.

My recommendations are for departments to set up training programs for the use of the LVNR and to have their training officers proficient in its instruction. Then the instructors can teach the LVNR department wide. Yearly in-service training should be required to prove the proficiency of the officer's knowledge and application of the restraint. Upon establishing a training system for the LVNR, departments should utilize the LVNR and place it at a reasonable level in the use of force continuum. I recommend the level just after other empty hand control techniques have failed and before impact weapons [batons]. I suggest that pepper spray be utilized before hard empty hand control is used as this may resolve the situation before further force is necessary.

These recommendations will give all officers an alternative for an effective countermeasure against the violence they face each day. We should not let inconclusive evidence and officer error keep this type of tool from the officer on the street. In today's world, they need all the help they can get.

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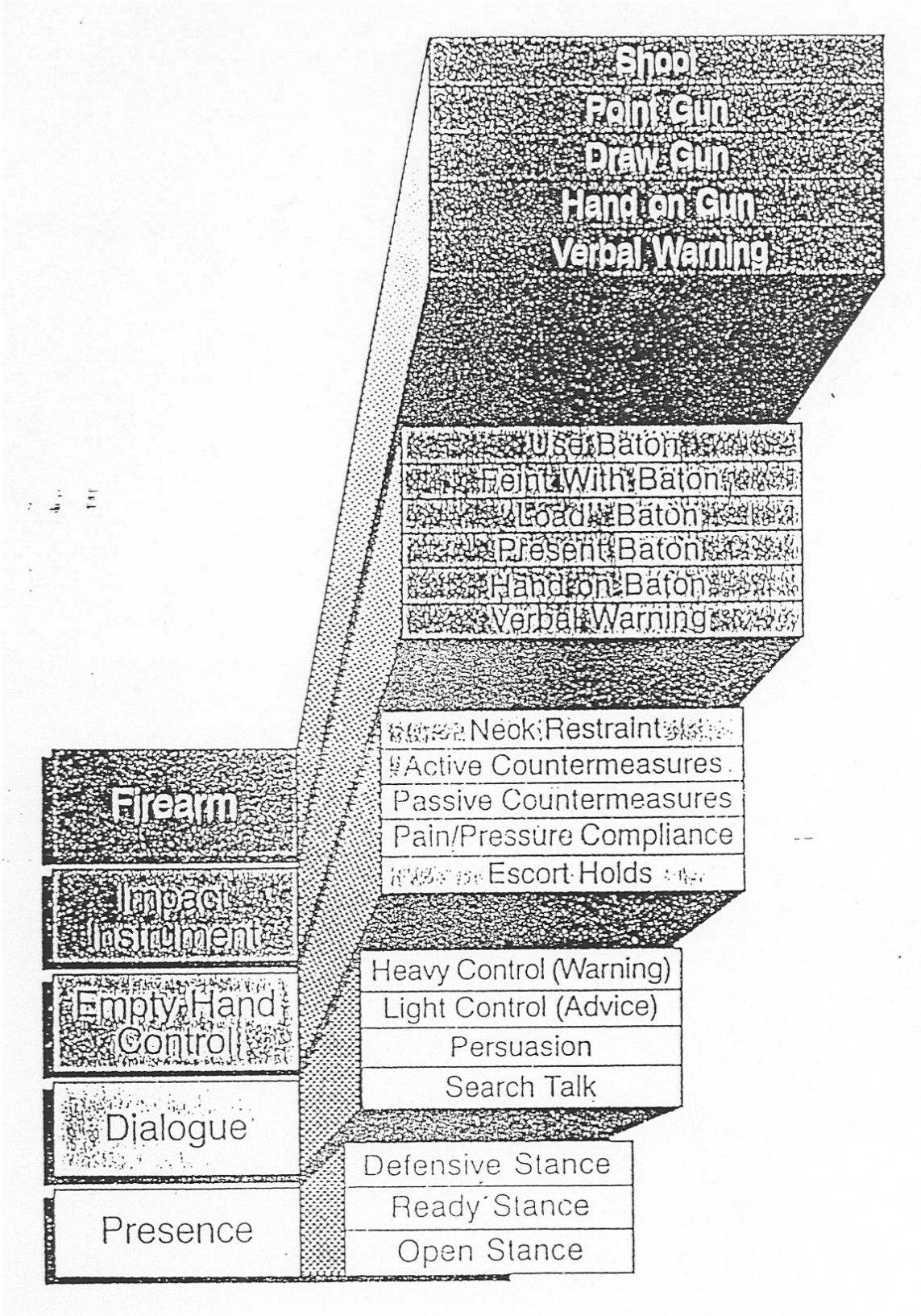

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Appendix A